OFFICE OF THE STATE CONTROLLER

STATE MANDATED COSTS CLAIMING INSTRUCTIONS NO. 2000-8

ANNUAL INSTRUCTIONS--LOCAL AGENCIES

September 29, 2000

Section 17561 of the Government Code provides for the reimbursement of state mandated costs. Enclosed is information for updating the Mandated Cost Manual for Cities, Counties, or Special Districts. The manual contains all forms and instructions that are necessary for local agencies to file 2000-01 annual claims with the State Controller's Office.

Estimated claims for costs to be incurred during the 2000-01 fiscal year and reimbursement claims that detail the costs actually incurred in the 1999-00 fiscal year must be filed with the State Controller's Office. Claims must be delivered or postmarked on or before January 16, 2001. If the claim is filed after the deadline, but by January 15, 2002, the approved claim will be reduced by a late penalty of 10%, not to exceed $1,000. In order for a claim to be considered properly filed, the claim must include supporting documentation specified in the instructions to substantiate the costs claimed. In addition, the claimant must explain the functions performed by each employee for whom costs were claimed. Claims will not be accepted if filed more than one year after the deadline, or without supporting documentation.

The fiscal years for which costs can be claimed for a mandated cost program are shown on pages 3 and 4 under "Reimbursable State Mandated Cost Programs." Amounts appropriated for payment of program costs are shown on pages 5 and 6 under "Appropriations for State Mandated Cost Programs—2000-01 Fiscal Year." To prepare 2000-01 estimated claims and 1999-00 reimbursement claims, forms in the manual should be duplicated to meet the local agency's filing requirements.

Claim amounts should be rounded to the nearest dollar. For each program, submit a signed original and a copy of form FAM-27, and a copy of all other forms and supporting documents, to:

Address, if delivery by: U.S. Postal Service	Address, if delivery by: Other delivery services
Office of the State Controller Attn: Local Reimbursements Section Division of Accounting and Reporting P.O. Box 942850 Sacramento, CA 94250	Office of the State Controller Attn: Local Reimbursements Section Division of Accounting and Reporting 3301 C Street, Suite 500 Sacramento, CA 95816

MINIMUM CLAIM COST

Government Code section 17564(a) provides that no claim or payment shall be made pursuant to section 17561 unless such a claim exceeds $200 per program per fiscal year. However, any county, as a fiscal agent, may submit a combined claim in excess of $200 on behalf of special districts within the county, even if an individual district's claim does not exceed two hundred dollars ($200). A combined claim must show the individual claim costs for each special district.

Once a combined claim is filed, all subsequent fiscal years relating to the same mandate must similarly be filed in a combined form. The county is responsible for disbursing funds to each participating district. A special district may withdraw from the combined claim form by providing the county and the State Controller's Office with a written notice of its intent to file a separate claim, at least 180 days prior to the filing deadline for filing the claim.

ESTIMATED CLAIMS

Unless otherwise specified in the claiming instructions, claimants do not have to provide cost schedules and supporting documents with the estimated claim if the estimated amount does not exceed the prior fiscal year's actual costs by more than 10%. The claimant can simply enter the estimated amount on form FAM-27, line (07). However, if the estimated claim exceeds the prior fiscal year's actual costs by more than 10%, the claimant must complete claim forms as specified for the program and explain the reason for increased costs. If the explanation to support the higher estimate is not provided with the claim, the claim will automatically be adjusted to 110% of the prior fiscal year's actual costs.

PROGRAM UPDATES FOR 2000-01 FISCAL YEAR

Ch. 486/75 Mandate Reimbursement Process

Ch. 486/75, Mandate Reimbursement Process, provides reimbursement for the cost of: (1) preparing and presenting successful test claims, and (2) preparing and submitting successful reimbursement claims to the State Controller's Office. With respect to preparing and submitting claims to the State Controller's Office, the 1999 State Budget Act (Ch. 52, Statutes of 2000), imposed in the 2000-01 fiscal year the same limitations as those imposed in the prior fiscal years. Limitations on reimbursement for independent contractor costs are as follows:

> "If a local agency or school district contracts with an independent contractor for the preparation and submission of reimbursement claims, the costs reimbursable by the state for that purpose shall not exceed the lesser of (1) 10 percent of the amount of the claims prepared and submitted by the independent contractor, or (2) the actual costs that would necessarily have been incurred for that purpose if performed by employees of the local agency.
>
> The maximum amount of reimbursement provided (in the above provision) may be exceeded only if the local agency or school district establishes, by appropriate documentation, that the preparation and submission of these claims could not have been accomplished without
> the incurring of the additional costs claimed by the local agency or school district."

Updates of Rates and Factors

The following are rates to be used for filing 1999-00 reimbursement claims. The 1999-00 rates are computed by adjusting the 1998-99 rate by the change in the Implicit Price Deflator (IPD) as determined by the State Department of Finance's report of July 28, 2000, *National Deflators, State and Local Purchases.* The estimated change in the IPD for 1999-00 is 3.7%. For preparing 2000-01 estimated claims, local agencies may use the program's 1999-00 rate or increase the 1999-00 rate by the estimated 2000-01 IPD change of 2.8% to determine 2000-01 estimated claim amounts.

In the subsequent fiscal year, the estimated amount must be adjusted to actual cost.

Senior Citizens' Property Tax Postponement, Ch. 1242/77 -- Counties with an established base year entitlement will receive an automatic payment through the State Mandates Apportionment System (See page 5 of the manual). The amount of increase for the 1999-00 apportionment is 3.7%. Counties without an established base year entitlement may file a 1999-00 reimbursement claim. The 1999-00 unit cost reimbursement rate for each document processed is $11.20.

Unitary Countywide Tax Rate, Ch. 921/87 -- The 1999-00 Implicit Price Deflator factor for adjusting the 1987-88 base year cost is 1.392.

REIMBURSABLE STATE MANDATED COSTS PROGRAMS

Local agencies may file claims with the State Controller's Office for the cost of complying with the following State mandated programs. The letters "a", "b", or "c", indicate the program and fiscal year that the local agency type may file a claim. The appropriations available to the State Controller's Office for paying 2000-01 claims are displayed in the schedule on pages 5 and 6, "Appropriations for State Mandated Cost Programs—2000-01 Fiscal Year." Appropriations available to pay 1999-00 claims are displayed in last year's claiming instructions under this same schedule.

"a" indicates that the program is applicable to cities, counties and special districts.
"b" indicates that the program is applicable to cities and counties.
"c" indicates that the program is applicable to counties only.

1999-00 Reimburse-ment Claim	2000-01 Estimated Claim			
a	a	Chapter	486/75	Mandate Reimbursement Process
c	c	Chapter	694/75	Developmentally Disabled: Attorney's Services
c	c	Chapter	1399/76	Child Abduction and Recovery
c	c	Chapter	498/77	Coroners
c	c	Chapter	1242/77	Senior Citizens Property Tax Postponement
a	a	Chapter	77/78	Absentee Ballots
c	c	Chapter	991/79	MDSO Recommitment
c	c	Chapter	1114/79	Not Guilty by Reason of Insanity
c	c	Chapter	1253/80	Mentally Retarded Representation
c	c	Chapter	1304/80	Conservatorships: Mentally Disabled Adults
b	b	Chapter	1143/80	Regional Housing Needs Assessment
c	c	Chapter	102/81	Medi-Cal Beneficiary Death Notices
c	c	Chapter	1422/82	Permanent Absentee Voters
a	a	Chapter	1568/82	Firefighters' Cancer Presumption

REIMBURSABLE STATE MANDATED COSTS PROGRAMS--Continued

1999-00 Reimburse-ment	2000-01 Estimated Claim			
c	c	Chapter	1747/84	Services to Handicapped Students
a	a	Chapter	641/86	Open Meetings Act
c	c	Chapter	921/87	Unitary Countywide Tax Rates
a	a	Chapter	391/88	Brendon Maguire Act
b	b	Chapter	1088/88	Search Warrant: AIDS
c	c	Chapter	1597/88	AIDS Testing
c	c	Chapter	955/89	SIDS Autopsies
a	a	Chapter	1111/89	SIDS Training for Firefighters
a	a	Chapter	1171/89	Peace Officers' Cancer Presumption
c	c	Chapter	1200/89	Pesticide Use Reports
b	b	Chapter	337/90	Stolen Vehicle Notifications
c	c	Chapter	1603/90	Perinatal Services
c	c	Chapter	268/91	SIDS Contact By Local Health Officers
b	b	Chapter	820/91	Prisoner Parental Rights
b	b	Chapter	999/91	Rape Victims Counseling Center Notices
b	b	Chapter	183/92	Domestic Violence Treatment Services Authorization and Case Management
c	c	Chapter	697/92	Allocation of Property Tax Revenue
b	b	Chapter	961/92	Pacific Beach Safety
b	b	Chapter	1105/92	Booking and Fingerprinting
a	a	Chapter	1111/89	Very High Fire Hazard Safety Zones
a	a	Chapter	1249/92	Threats Against Peace Officers
a	a	Chapter	644/94	Airport Land Use Commission/Plans
b	b	Chapter	1297/94	Two-way Traffic Signal Communication
b	b	Chapter	246/95	Domestic Violence Arrest Policies & Standards
c	c	Chapter	411/95	Crime Victims' Rights
c	c	Chapter	762/95	Sexually Violent Predators
a	a	Chapter	783/95	Investment Reports

APPROPRIATIONS FOR STATE MANDATED COST PROGRAMS—2000-01 FISCAL YEAR

Source of State Mandated Cost Appropriations	Amounts Appropriated
1999 State Budget Act (Chapter 52/00)	
Mandated Programs	
Item 0820-295-0001 Department of Justice	
Ch. 1399/76 Child Abduction and Recovery	$10,177,000
Ch. 337/90 Stolen Vehicle Notification	351,000
Ch. 1105/92 Misdemeanors: Booking/Fingerprinting	990,000
Item 0890-295-0001 Secretary of State	
Ch. 77/78 Absentee Ballots	6,111,000
Ch. 391/88 Brendon Maguire Act	1,000
Ch. 704/75 Registration By Mail	1,416,000
Ch. 1422/82 Permanent Absentee Voters	325,000
Item 0950-295-0001 State Treasurer	
Ch. 783/95 Investment Reports	3,342,000
Item 2240-295-0001 Department of Community and Housing Development	
Ch. 1143/80 Regional Housing Needs Assessments	850,000
Item 3930-295-0001 Department of Pesticide Regulations	
Ch.1200/89 Pesticide Use Reports	225,000
Item 4260-295-0001 Department of Health Services	
Ch. 268/91 Sudden Infant Death Syndrome: Contact By Health Services	325,000
Ch. 961/92 Pacific Beach Safety	71,000
Ch. 955/89 Sudden Infant Death Syndrome: Autopsies	1,869,000
Ch. 1088/88 Search Warrants: AIDS	899,000
Ch. 102/81 Medi-Cal Beneficiary Death Notices	100,000
Ch. 1597/88 AIDS Testing	1,241,000
Ch. 1603/90 Perinatal Services	2,686,000
Item 4300-295-0001 Department of Developmental Services	
Ch. 644/80 Judicial Proceedings	87,000
Ch. 694/75 Attorney Services for Developmentally Disabled	189,000
Ch. 1253/80 Mentally Retarded Representation	107,000
Ch. 1304/80 Conservatorships: Developmentally Disabled Adults	103,000
Item 4440-295-0001 Department of Mental Health	

Ch. 498/77	Coroners	107,000
Ch. 991/79	Mentally Disordered Sex Offenders: Recommitment	189,000

APPROPRIATIONS FOR STATE MANDATED COST PROGRAMS—2000-01 FISCAL YEAR--Continued

Source of State Mandated Cost Appropriations		Amounts Appropriated
Item 4440-295-0001 Department of Mental Health (continued)		
Ch. 1114/79	Not Guilty By Reason of Insanity	298,000
Ch. 1747/84	Services to Handicapped Students	39,488,000
Ch. 762/95	Sexually Violent Predators	4,067,000
Item 5240-295-0001 Department of Corrections		
Ch. 820/91	Prisoner Parental Rights	1,958,000
Item 5430-295-0001 Board of Corrections		
Ch. 221/93	Domestic Violence Treatment Program Approvals[1]	733,000
Item 8100-295-0001 Office of Criminal Justice Planning		
Ch. 1249/92	Threats Against Peace Officers	5,000
Ch. 411/95	Crime Victims' Rights	803,000
Item 8120-295-0001 Commission on Peace Officer Standards and Training		
Ch. 246/95	Domestic Violence Arrest Policies and Standards	6,781,000
Item 8350-295-0001 Department of Industrial Relations		
Ch. 1171/89	Peace Officers' Cancer Presumption	748,000
Ch. 1568/82	Firefighters' Cancer Presumption	719,000
Item 9100-295-0001 Tax Relief		
Ch. 1242/77	Senior Citizens' Property Tax Postponement	277,000
Ch. 921/87	Unitary Countywide Tax Rates	368,000
Ch. 697/92	Allocation of Property Tax Revenue	362,000
Item 9210-295-0001 Local Government Financing		
Ch. 486/75	Test Claims and Reimbursement Claims	3,023,000
Ch. 641/86	Open Meetings Act	2,896,000
Ch. 999/91	Rape Victims Counseling Center Notices	153,000
TOTAL--Funding for the 2000-01 Fiscal Year		**$94,440,000**

[1]No claims shall be filed for Ch. 221/93, Domestic Violence Treatment Program Approvals. This program was repealed on 1-1-96.

NEW CLAIMING INSTRUCTIONS ON THE HORIZON

The following programs were successful with the Test Claim process at the Commission on State Mandates. Parameters and guidelines (P's & G's) for these programs have recently been adopted, or are pending adoption at the Commission on State Mandates. This office will issue the program's reimbursement claiming instructions on the Controller's web site **www.sco.ca.gov/ard/local/locreim/index/htm** within 60 days of receiving the P's and G's from the Commission. Programs are as following:

- Child Abuse Treatment Services Authorization, Ch. 1090/96
- Sexual Harassment Training in the Law Enforcement Workplace, Ch. 126/92
- Not Guilty by Reason of Insanity, Ch. 1114/79 (Revised claiming instructions)

PROGRAMS SUSPENDED FOR THE 2000-01 FISCAL YEAR

Pursuant to Government Code Section 17581, the following state mandated programs are identified in the 1999 State Budget Act (Ch 52/00), with a $0 appropriation by the Legislature. The following state mandated programs have been suspended for the 2000-01 fiscal year, and no 2000-01 claim shall be filed:

Ch.	238/74	Substandard Housing
Ch.	1131/75	Mineral Resource Policies
Ch.	1330/76	Local Coastal Program
Ch.	1357/76	Guardianship and Conservatorship Filings
Ch.	1401/76	Voter Registration Roll Purge
Ch.	1123/77	Adult Felony Restitution
Ch.	845/78	Filipino Employee Survey
Ch.	815/79	Short-Doyle Case Management
Ch.	494/79	Handicapped Voter Access
Ch.	1032/80	Deaf Teletype Equipment
Ch.	1281/80	Involuntary Lien Notices
Ch.	332/81	Victims Statement-Minors
Ch.	889/81	Lis Pendens
Ch.	1013/81	Local Elections: Consolidations
Ch.	1051/83	Senior Citizens Mobilehome Property Tax Deferral
Ch.	980/84	Court Audits and Proration of Fines
Ch.	1327/84	Short-Doyle Audits
Ch.	1609/84	Domestic Violence Information
Ch.	1042/85	Election Materials
Ch.	1352/85	Residential Care Services
Ch.	48/87	Property Taxation: Family Transfers
Ch.	1334/87	CPR Pocket Masks
Ch.	8/88	Democratic Presidential Delegates
Title	8, CCR	Personal Alarm Devices (Section 3401 (c))

Title 8, CCR Structural & Wildland Firefighters Clothing and Equipment
(Sections 3401-3410)

AUDIT OF COSTS

All claims submitted to the State Controller's Office are reviewed to determine if costs are related to the mandate, costs are reasonable and not excessive, and the claim was prepared in accordance with the claiming instructions. If any adjustments are made to a claim, a "Notice of Claim Adjustment" will be mailed within 30 days after payment of the claim. The notice will specify the claim component adjusted, the amount adjusted, and the reason for the adjustment.

On-site audits will be conducted by the State Controller's Office as deemed necessary. Accordingly, documentation to support actual costs claimed must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended. Claim documentation shall be made available to the State Controller's Office on request.

RETENTION OF CLAIMING INSTRUCTIONS

Claiming instructions and forms in this package should be retained permanently in the Mandated Cost Manual for future reference and use in filing claims. The forms should be duplicated to meet your filing requirements. Each year, the State Controller's Office will place on its web site updated forms and any other information or instructions claimants may need to file claims. Each vertical line next to the page margin indicates the place where a revision was made to the instructions or form. When the costs of a new program are claimable, instructions to claim these costs will be placed on the web site for claimants.

If you have any questions concerning mandated cost reimbursements, please write to us at the address listed for filing claims, e-mail to **gibrummels@sco.ca.gov**, or call the Local Reimbursements Section at (916) 323-3258.

MANDATED COST MANUALS
REVISIONS
SEPTEMBER 2000

REMOVE	INSERT
For Counties	
State Mandated Cost Programs, pages 47 and 48 (Revised 10/99)	State Mandated Cost Programs, pages 47 and 48 (Revised 9/00)
Ch. 486/75, Mandate Reimbursement Process, form FAM-27 (Revised 4/96)	Ch. 486/75, Mandate Reimbursement Process, form FAM-27 (Revised 9/00)
Ch. 694/75, Developmentally Disabled: Attorney's Services, form FAM-27 (Revised 10/96)	Ch. 694/75, Developmentally Disabled: Attorney's Services, form FAM-27 (Revised 9/00)
Ch. 1399/76, Child Abduction and Recovery, form FAM-27 (Revised 10/99)	Ch. 1399/76, Child Abduction and Recovery, form FAM-27 (Revised 9/00)
Ch. 498/77, Coroners, form FAM-27 (Revised 10/95)	Ch. 498/77, Coroners, form FAM-27 (Revised 9/00)
Ch. 1242/77, Sr. Citizen Property Tax Deferral, form FAM-27 (Revised 10/96) and SCPT-1 (Revised 10/99)	Ch. 1242/77, Sr. Citizen Property Tax Deferral, forms FAM-27 and SCPT-1 (Revised 9/00)
Ch. 77/78, Absentee Ballots, form FAM-27 (Revised 2/98)	Ch. 77/78, Absentee Ballots, form FAM-27 (Revised 9/00)
Ch. 991/79, Mentally Disordered Sex Offenders: Extended Commitments, form FAM-27 (Revised 10/95)	Ch. 991/79, Mentally Disordered Sex Offenders: Extended Commitments, form FAM-27 (Revised 9/00)
Ch. 1143/80, Regional Housing Need Determination, form FAM-27 (Revised 11/98)	Ch. 1143/80, Regional Housing Need Determination, form FAM-27 (Revised 9/00)
Ch. 1253/80, Mentally Retarded Defendants: Diversion, forms FAM-27 (Revised 10/95)	Ch. 1253/80, Mentally Retarded Defendants: Diversion, forms FAM-27 (Revised 9/00)
Ch. 1304/80, Conservatorship: Developmentally Disabled Adults, form FAM-27 (Revised 9/95)	Ch. 1304/80, Conservatorship: Developmentally Disabled Adults, form FAM-27 (Revised 9/00)
Ch. 102/81, Medi-Cal Beneficiary Death Notices, form FAM-27 (Revised 10/95)	Ch. 102/81, Medi-Cal Beneficiary Death Notices, form FAM-27 (Revised 9/00)
Ch. 1422/82, Permanent Absentee Voters, form FAM-27 (Revised 10/95)	Ch. 1422/82, Permanent Absentee Voters, form FAM-27 (Revised 9/00)
Ch. 1568/82, Firefighters Cancer Presumption, form FAM-27 (Revised 10/96)	Ch. 1568/82, Firefighters Cancer Presumption, form FAM-27 (Revised 9/00)
Ch. 1747/84, Services to Handicapped Students, form FAM-27 (Revised 3/97)	Ch. 1747/84, Services to Handicapped Students, form FAM-27 (Revised 9/00)

MANDATED COST MANUALS
REVISIONS
SEPTEMBER 2000

REMOVE	INSERT
For Counties (continued)	
Ch. 641/86, Open Meetings Act, form FAM-27 (Revised 10/95)	Ch. 641/86, Open Meetings Act, form FAM-27 (Revised 9/00)
Ch. 921/87, Unitary Countywide Tax Rate, forms CTR-1 (Revised 10/99) and FAM-27 (Revised 3/97)	Ch. 921/87, Unitary Countywide Tax Rate, forms CTR-1 and FAM-27 (Revised 9/00)
Ch. 391/88, Brendon Maguire Act, form FAM-27 (Revised 10/95)	Ch. 391/88, Brendon Maguire Act, form FAM-27 (Revised 9/00)
Ch. 1088/88, Search Warrant: AIDS, form FAM-27 (Revised 10/95)	Ch. 1088/88, Search Warrant: AIDS, form FAM-27 (Revised 9/00)
Ch. 1597/88, AIDS Testing, form FAM-27 (Revised 10/95)	Ch. 1597/88, AIDS Testing, form FAM-27 (Revised 9/00)
Ch. 955/89, Sudden Infant Death Syndrome: Autopsy Protocols, form FAM-27 (Revised 10/95)	Ch. 955/89, Sudden Infant Death Syndrome: Autopsy Protocols, form FAM-27 (Revised 9/00)
Ch. 1111/89, Sudden Infant Death Syndrome Training for Firefighters, form FAM-27 (New 7/99)	Ch. 1111/89, Sudden Infant Death Syndrome Training for Firefighters, form FAM-27 (Revised 9/00)
Ch. 1171/89, Cancer Presumption-Peace Officers, form FAM-27 (Revised 10/96)	Ch. 1171/89, Cancer Presumption-Peace Officers, form FAM-27 (Revised 9/00)
Ch. 1200/89, Pesticide Use Reports, form FAM-27 (New 3/97)	Ch. 1200/89, Pesticide Use Reports, form FAM-27 (Revised 9/00)
Ch. 337/90, Stolen Vehicle Notification, form FAM-27 (New 4/96)	Ch. 337/90, Stolen Vehicle Notification, form FAM-27 (Revised 9/00)
Ch. 1063/90, Perinatal Services, form FAM-27 (New 4/96)	Ch. 1063/90, Perinatal Services, form FAM-27 (Revised 9/00)
Ch. 268/91, SIDS: Contact by Local Health Officer, form FAM-27 (Revised 10/95)	Ch. 268/91, SIDS: Contact by Local Health Officer, form FAM-27 (Revised 9/00)
Ch. 820/91, Prisoner Parental Rights, form FAM-27 (Revised 1/98)	Ch. 820/91, Prisoner Parental Rights, form FAM-27 (Revised 9/00)
Ch. 999/91, Rape Victim Counseling Center Notices, form FAM-27 (New 4/96)	Ch. 999/91, Rape Victim Counseling Center Notices, form FAM-27 (Revised 9/00)
Ch. 183/92, Domestic Violence Treatment Services-Authorization and Case Management, form FAM-27 (New 2/99)	Ch. 183/92, Domestic Violence Treatment Services-Authorization and Case Management, form FAM-27 (Revised 9/00)

MANDATED COST MANUALS
REVISIONS
SEPTEMBER 2000

REMOVE	INSERT
For Counties (continued)	
Ch. 697/92, Allocation of Property Tax Revenue: Educational Revenue Augmentation Funds, form FAM-27 (Revised 9/97)	Ch. 697/92, Allocation of Property Tax Revenue: Educational Revenue Augmentation Funds, form FAM-27 (Revised 9/00)
Ch. 961/92, Pacific Beach Safety, form FAM-27 (New 4/96)	Ch. 961/92, Pacific Beach Safety, form FAM-27 (Revised 9/00)
Ch. 1105/92, Misdemeanors: Booking and Fingerprinting, form FAM-27 (New 4/96)	Ch. 1105/92, Misdemeanors: Booking and Fingerprinting, form FAM-27 (Revised 9/00)
Ch. 1188/92, Very High Fire Hazard Severity Zones, form FAM-27 (Revised 10/99)	Ch. 1188/92, Very High Fire Hazard Severity Zones, form FAM-27 (Revised 9/00)
Ch. 1249/92, Threats Against Peace Officers, form FAM-27 (New 5/98)	Ch. 1249/92, Threats Against Peace Officers, form FAM-27 (Revised 9/00)
Ch. 644/94, Airport Land Use Commission/Plans, form FAM-27 (New 3/99)	Ch. 644/94, Airport Land Use Commission/Plans, form FAM-27 (Revised 9/00)
Ch. 1297/94, Two-Way Traffic Signal Communication, form FAM-27 (New 11/98)	Ch. 1297/94, Two-Way Traffic Signal Communication, form FAM-27 (Revised 9/00)
Ch. 246/95, Domestic Violence Arrest Policies and Standards, form FAM-27 (New 10/98)	Ch. 246/95, Domestic Violence Arrest Policies and Standards, form FAM-27 (Revised 9/00)
Ch. 411/95, Crime Victims' Rights, form FAM-27 (New 7/97)	Ch. 411/95, Crime Victims' Rights, form FAM-27 (Revised 9/00)
Ch. 762/95, Sexually Violent Predators, form FAM-27 (New 11/98)	Ch. 762/95, Sexually Violent Predators, form FAM-27 (Revised 9/00)
Ch. 783/95, Investment Reports, form FAM-27 (New 1/98)	Ch. 783/95, Investment Reports, form FAM-27 (Revised 9/00)

MANDATED COST MANUALS
REVISIONS
SEPTEMBER 2000

REMOVE	INSERT
For Cities	
State Mandated Cost Programs, page 47 (Revised 10/99)	State Mandated Cost Programs, page 47 (Revised 9/00)
Ch. 486/75, Mandate Reimbursement Process, form FAM-27 (Revised 4/96)	Ch. 486/75, Mandate Reimbursement Process, form FAM-27 (Revised 9/00)
Ch. 77/78, Absentee Ballots, form FAM-27 (Revised 2/98)	Ch. 77/78, Absentee Ballots, form FAM-27 (Revised 9/00)
Ch. 1143/80, Regional Housing Need Determination, form FAM-27 (Revised 11/98)	Ch. 1143/80, Regional Housing Need Determination, form FAM-27 (Revised 9/00)
Ch. 1568/82, Firefighters Cancer Presumption, form FAM-27 (Revised 10/96)	Ch. 1568/82, Firefighters Cancer Presumption, form FAM-27 (Revised 9/00)
Ch. 641/86, Open Meetings Act, form FAM-27 (Revised 10/95)	Ch. 641/86, Open Meetings Act, form FAM-27 (Revised 9/00)
Ch. 391/88, Brendon Maguire Act, form FAM-27 (Revised 10/95)	Ch. 391/88, Brendon Maguire Act, form FAM-27 (Revised 9/00)
Ch. 1088/88, Search Warrant: Aids, form FAM-27 (Revised 10/95)	Ch. 1088/88, Search Warrant: Aids, form FAM-27 (Revised 9/00)
Ch. 1111/89, SIDS Training for Firefighters, form FAM-27 (Revised 7/99)	Ch. 1111/89, SIDS Training for Firefighters, form FAM-27 (Revised 9/00)
Ch. 1171/89, Cancer Presumption Peace Officers, form FAM-27 (Revised 10/96)	Ch. 1171/89, Cancer Presumption Peace Officers, form FAM-27 (Revised 9/00)
Ch. 337/90, Stolen Vehicle Notification, form FAM-27 (Revised 4/96)	Ch. 337/90, Stolen Vehicle Notification, form FAM-27 (Revised 9/00)
Ch. 820/91, Prisoner Parental Rights, form FAM-27 (Revised 1/98)	Ch. 820/91, Prisoner Parental Rights, form FAM-27 (Revised 9/00)
Ch. 999/91, Rape Victim Counseling Center Notices, form FAM-27 (New 4/96)	Ch 999/91, Rape Victim Counseling Center Notices, form FAM-27 (Revised 9/00)
Ch. 183/92, Domestic Violence Treatment Services: Authorization and Case Management, form FAM-27 (Revised 2/99)	Ch. 183/92, Domestic Violence Treatment Services: Authorization and Case Management form FAM-27 (Revised 9/00)
Ch. 961/92, Pacific Beach Safety, form FAM-27 (New 4/96)	Ch. 961/92, Pacific Beach Safety, form FAM-27 (Revision 9/00)
Ch. 1105/92, Misdemeanors: Booking and Fingerprinting, form FAM-27 (New 4/96)	Ch. 1105/92, Misdemeanors: Booking and Fingerprinting, form FAM-27 (Revision 9/00)

MANDATED COST MANUALS
REVISIONS
SEPTEMBER 2000

REMOVE	INSERT
For Cities *(continued)*	
Ch. 1249/92, Threats Against Peace Officers, form FAM-27 (New 5/98)	Ch. 1249/92, Threats Against Peace Officers, form FAM-27 (Revised 9/00)
Ch. 644/94, Airport Land Use Commission /Plans, form FAM-27 (New 3/99)	Ch. 644/94, Airport Land Use Commission /Plans, form FAM-27 (Revised 9/00)
Ch. 1297/94, Two Way Traffic Signal Communication, form FAM-27 (New 11/98)	Ch. 1297/94, Two Way Traffic Signal Communication, form FAM-27 (Revised 9/00)
Ch. 246/95, Domestic Violence Arrest Policies and Standards, form FAM-27 (New 10/98)	Ch. 246/95, Domestic Violence Arrest Policies and Standards, form FAM-27 (Revised 9/00)
Ch. 783/95, Investment Reports, form FAM-27 (New 1/98)	Ch. 783/95, Investment Reports, form FAM-27 (Revised 9/00)

MANDATED COST MANUALS
REVISIONS
SEPTEMBER 2000

REMOVE	INSERT
For Special Districts	
State Mandated Cost Programs, page 47 (Revised 10/98)	State Mandated Cost Programs, page 47 (Revised 10/99)
Ch. 486/75, Mandate Reimbursement Process, form FAM-27 (Revised 4/96)	Ch. 486/75, Mandate Reimbursement Process, form FAM-27 (Revised 9/00)
Ch. 77/78, Absentee Ballots, form FAM-27 (Revised 2/98)	Ch. 77/78, Absentee Ballots, form FAM-27 (Revised 9/00)
Ch. 1143/80, Regional Housing Need Determination, form FAM-27 (Revised 11/98)	Ch. 1143/80, Regional Housing Need Determination, form FAM-27 (Revised 9/00)
Ch. 1568/82, Firefighters Cancer Presumption, form FAM-27 (Revised 10/96)	Ch. 1568/82, Firefighters Cancer Presumption, form FAM-27 (Revised 9/00)
Ch. 641/86, Open Meetings Act, form FAM-27 (Revised 10/95)	Ch. 641/86, Open Meetings Act, form FAM-27 (Revised 9/00)
Ch. 391/88, Brendon Maguire Act, form FAM-27 (Revised 10/95)	Ch. 391/88, Brendon Maguire Act, form FAM-27 (Revised 9/00)
Ch. 1111/89, Sudden Infant Death Syndrome Training for Firefighters, form FAM-27 (Revised 7/99)	Ch. 1111/89, Sudden Infant Death Syndrome Training for Firefighters, form FAM-27 (Revised 9/00)
Ch. 1171/89, Cancer Presumption-Peace Officers, form FAM-27 (Revised 10/96)	Ch. 1171/89, Cancer Presumption-Peace Officers, form FAM-27 (Revised 9/00)
Ch. 1188/92, Very High Fire Hazard Severity Zones, form FAM-27 (Revised 10/99)	Ch. 1188/92, Very High Fire Hazard Severity Zones, form FAM-27 (Revised 9/00)
Ch. 1249/92, Threats Against Peace Officers, form FAM-27 (Revised 5/98)	Ch. 1249/92, Threats Against Peace Officers, form FAM-27 (Revised 9/00)
Ch. 644/94, Airport Land Use Commissions /Plans, form FAM-27 (New 3/99)	Ch. 644/94, Airport Land Use Commissions /Plans, form FAM-27 (Revised 9/00)
Ch. 783/95, Investment Reports, form FAM-27 (New 1/98)	Ch. 783/95, Investment Reports, form FAM-27 (Revised 9/00)

STATE MANDATED COST PROGRAMS – COUNTIES

The following is a listing of mandated cost programs included in this manual. The programs are arranged in chapter order by statute year (i.e., Chapter 486, Statutes of 1975, is represented as Chapter 486/75). In instances where more than one chapter/statute is shown for a mandated program, the earliest chapter/statute identifies its place in the manual.

Chapter	486/75	Mandate Reimbursement Process
Chapter	694/75	Developmentally Disabled: Attorneys' Services
Chapter	1399/76	Child Abduction and Recovery
Chapter	498/77	Coroners
Chapter	1242/77	Senior Citizens Property Tax Postponement
Chapter	77/78	Absentee Ballots
Chapter	913/79	Domestic Violence Diversion Program Close Out
Chapter	991/79	MDSO Recommitments
Chapter	1114/79	Not Guilty by Reason of Insanity
Chapter	1143/80	Regional Housing Need Determination
Chapter	1253/80	Mentally Retarded Defendants: Diversion
Chapter	1304/80	Conservatorship: Developmentally Disabled Adults
Chapter	102/81	Medi-Cal Beneficiary Death Notices
Chapter	1422/82	Permanent Absentee Voters
Chapter	1568/82	Firefighters Cancer Presumption
Chapter	1747/84	Services to Handicapped Students
Chapter	641/86	Open Meetings Act
Chapter	921/87	Unitary Countywide Tax Rate
Chapter	391/88	Brendon Maguire Act
Chapter	1088/88	Search Warrant: AIDS
Chapter	1597/88	AIDS Testing

STATE MANDATED COST PROGRAMS – COUNTIES (continued)

Chapter	955/89	Sudden Infant Death Syndrome: Autopsies
Chapter	1111/89	Sudden Infant Death Syndrome: Training for Firefighters
Chapter	1171/89	Peace Officers' Cancer Presumption
Chapter	1200/89	Pesticide Use Reports
Chapter	337/90	Stolen Vehicles Notification
Chapter	1603/90	Perinatal
Chapter	268/91	SIDS: Contact By Local Health Officer
Chapter	820/91	Prisoner Parental Rights
Chapter	999/91	Rape Victim Counseling Center Notices
Chapter	183/92	Domestic Violence Treatment Services-Authorization and Case Management
Chapter	697/92	Allocation of Property Tax Revenues: ERAF
Chapter	961/92	Pacific Beach Safety
Chapter	1105/92	Misdemeanors: Booking and Fingerprinting
Chapter	1188/92	Very High Fire Hazard Severity Zones
Chapter	1249/92	Threats Against Peace Officers
Chapter	644/94	Airport Land Use Commission/Plans
Chapter	1297/94	Two-Way Traffic Signal Communication
Chapter	246/95	Domestic Violence Arrest Policies and Standards
Chapter	411/95	Crime Victims' Rights
Chapter	762/95	Sexually Violent Predators
Chapter	783/95	Investment Reports

STATE MANDATED COST PROGRAMS – CITIES

The following is a listing of mandated cost programs included in this manual. The programs are arranged in chapter order by statute year (i.e., Chapter 486, Statutes of 1975, is represented as Chapter 486/75). In instances where more than one chapter/statute is shown for a mandated program, the earliest chapter/statute identifies its place in the manual.

Chapter 486/75 Mandate Reimbursement Process

Chapter 77/78 Absentee Ballots

Chapter 1143/80 Regional Housing Need Determination

Chapter 1568/82 Firefighters Cancer Presumption

Chapter 1490/84 Business Tax Reporting Requirements

Chapter 641/86 Open Meetings Act

Chapter 391/88 Brendon Maguire Act
Chapter 1088/88 Search Warrant: AIDS

Chapter 1111/89 Sudden Infant Death Syndrome: Training for Firefighters
Chapter 1171/89 Peace Officers' Cancer Presumption

Chapter 337/90 Stolen Vehicles Notification

Chapter 820/91 Prisoner Parental Rights
Chapter 999/91 Rape Victim Counseling Center Notices

Chapter 183/92 Domestic Violence Treatment Services-Authorization and Case Management
Chapter 961/92 Pacific Beach Safety
Chapter 1105/92 Misdemeanors: Booking and Fingerprinting
Chapter 1249/92 Threats Against Peace Officers

Chapter 644/94 Airport Land Use Commission/Plans
Chapter 1297/94 Two-Way Traffic Signal Communication

Chapter 246/95 Domestic Violence Arrest Policies and Standards
Chapter 783/95 Investment Reports

STATE MANDATED COST PROGRAMS – SPECIAL DISTRICTS

The following is a listing of mandated cost programs included in this manual. The programs are arranged in chapter order by statute year (i.e., Chapter 486, Statutes of 1975, is represented as Chapter 486/75). In instances where more than one chapter/statute is shown for a mandated program, the earliest chapter/statute identifies its place in the manual.

Chapter 486/75 Mandate Reimbursement Process

Chapter 77/78 Absentee Ballots

Chapter 1143/80 Regional Housing Need Determination

Chapter 1568/82 Firefighters Cancer Presumption

Chapter 641/86 Open Meetings Act

Chapter 391/88 Brendon Maguire Act

Chapter 1111/89 Sudden Infant Death Syndrome: Training for Firefighters

Chapter 1171/89 Peace Officers' Cancer Presumption

Chapter 1249/92 Threats Against Peace Officers

Chapter 644/94 Airport Land Use Commission/Plans

Chapter 783/95 Investment Reports

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
MANDATE REIMBURSEMENT PROCESS

For State Controller Use Only

(19) Program Number 00041
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22) MRP-1, (03)(a)	
(23) MRP-1, (03)(b)	
(24) MRP-1, (03)(c)	
(25) MRP-1, (04)(1)(d)	
(26) MRP-1, (04)(2)(d)	
(27) MRP-1, (04)(3)(d)	
(28) MRP-1, (06)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 486, Statutes of 1975 and Chapter 1459, Statutes of 1984; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 486, Statutes of 1975 and Chapter 1459, Statutes of 1984.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 486, Statutes of 1975 and Chapter 1459, Statutes of 1984, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

MANDATE REIMBURSEMENT PROCESS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form MRP-1 and enter the amount from line (11). If more than one form is completed due to multiple department involvement in this mandate, add line (11) of each form MRP-1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form MRP-1, line (11). If more than one form is completed due to multiple department involvement in this mandate, add line (11) of each form MRP-1.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. MRP-1, (03)(a), means the information is located on form MRP-1, line (03)(a). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
DEVELOPMENTALLY DISABLED: ATTORNEY SERVICES

For State Controller Use Only

(19) Program Number 00087
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	DDAS-1, (03)(1)	
(23)	DDAS-1, (03)(2)	
(24)	DDAS-1, (04)(1)(d)	
(25)	DDAS-1, (04)(2)(d)	
(26)	DDAS-1, (06)	
(27)	DDAS-1, (11)	
(28)		
(29)		
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 694, Statutes of 1975, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 694, Statutes of 1975.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 694, Statutes of 1975, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

DEVELOPMENTALLY DISABLED: ATTORNEY SERVICES **Certification Claim Form** **Instructions**	**FORM FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form DDAS-1 and enter the amount from line (11). If more than one DDAS-1 is completed due to multiple department involvement in this mandate, add line (11) of each form DDAS-1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form DDAS-1, line (11). If more than one DDAS-1 is completed due to multiple department involvement in this mandate, add line (11) of each form DDAS-1.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. DDAS-1, (03)(1), means the information is located on form DDAS-1, line (03)(1). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
CHILD ABDUCTION AND RECOVERY

For State Controller Use Only

(19) Program Number 00013
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	CAR-1, (03)(a)	
(23)	CAR-1, (03)(b)	
(24)	CAR-1, (04)(1)(f)	
(25)	CAR-1, (04)(2)(f)	
(26)	CAR-1, (06)	
(27)		
(28)		
(29)		
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1399, Statutes of 1976, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1399, Statutes of 1976.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1399, Statutes of 1976, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

CHILD ABDUCTION AND RECOVERY **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form CAR-1 and enter the amount from line (11). If more than one form CAR-1 is completed due to multiple department involvement in this mandate, add line (11) of each form CAR-1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form CAR-1, line (11). If more than one form CAR-1 is completed due to multiple department involvement in this mandate, add line (11) of each form CAR-1.

(14) The 1998/99 reimbursement claim is due February 28, 2000. In subsequent years reimbursement claims must be filed by January 15 of the fiscal year in which costs were incurred or the claims shall be reduced by a late penalty. Enter the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. CAR-1, (03)(a), means the information is located on form CAR-1, line (03)(a). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
CORONERS

For State Controller Use Only

(19) Program Number 00088
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) CO-1, (03)	
(23) CO-1, (04)(d)	
(24) CO-1, (05)	
(25)	
(26)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 498, Statutes of 1977, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 498, Statutes of 1977.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 498, Statutes of 1977, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

CORONERS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form CO-1 and enter the amount from line (10).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form CO-1, line (10).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. CO-1, (03), means the information is located on form CO-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SENIOR CITIZENS PROPERTY TAX POSTPONEMENT

For State Controller Use Only

(19) Program Number 00018
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) SCPT-1, (06)	
(23) SCPT-1, (08)	
(24)	
(25)	
(26)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1242, Statutes of 1977, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1242, Statutes of 1977.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1242, Statutes of 1977, set forth on the attached statements.

Signature of Authorized Representative Date

_____ _____

_____ _____

Type or Print Name Title

(39) Name of Contact Person for Claim

Telephone Number (_____) _____ _____ Ext. _____

_____ E-mail Address _____

SENIOR CITIZENS PROPERTY TAX POSTPONEMENT Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form SCPT-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form SCPT-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. SCPT-1, (06), means the information is located on form SCPT-1, line (06). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

MANDATED COSTS **SENIOR CITIZENS PROPERTY TAX POSTPONEMENT** **CLAIM SUMMARY**	**FORM SCPT-1**

(01) Claimant	(02) Type of Claim		Fiscal Year
	Reimbursement	☐	
	Estimated	☐	19___/20___
	Entitlement	☐	

Claim Statistics	
(03) Number of Certificates of Eligibility	
(04) Number of Notices of Liens	
(05) Number of Releases of Liens	
(06) Total Number of Documents	
Reimbursement Rate	
(07) Unit Cost: 1999-00 Reimbursement Claim: $11.20 2000-01 Estimated Claim: $11.51	
(08) Total Cost [Line (06) x line (07)]	
Cost Reduction	
(09) Less: Offsetting Savings, if applicable	
(10) Less: Other Reimbursements, if applicable	
(11) Total Claimed Amount [Line (08) – {line (09) + line (10)}]	

SENIOR CITIZENS PROPERTY TAX POSTMENT CLAIM SUMMARY Instructions	FORM SCPT-1

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement, Estimated, or Entitlement, to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

Form SCPT-1 must be filed for a reimbursement claim. Do not complete form SCPT-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form SCPT-1 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) Enter the total number of Certificates of Eligibility deposited during the fiscal year claimed. Include only those documents that have been filed and sent to the State Controller's Office during the fiscal year.

(04) Enter the total number of Notices of Liens completed for senior citizens who obtained a Senior Citizen Tax Postponement Lien on a particular parcel for the first time. Claim only those documents that have been filed and sent to the State Controller's Office during the fiscal year.

(05) Enter the total number of Releases of Liens completed for senior citizens who obtained a Senior Citizen Tax Postponement Lien on a particular parcel for the first time. Claim only those documents that have been filed and sent to the State Controller's Office during the fiscal year.

(06) Add total number of documents from lines (03), (04), and (05).

(07) Enter the appropriate unit cost rate given for the fiscal year in which costs were incurred or are to be incurred.

(08) Multiply Total Number of Documents, line (06), by Unit Cost, line (07).

(09) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(10) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any local agency source (i.e., service fees collected, federal funds, other state funds, etc.) which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(11) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09), and Other Reimbursements, line (10), from Total Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

If you are filing an Entitlement Claim, subtract the sum of Offsetting Savings, line (09), and Other Reimbursements, line (10), from Total Cost, line (08). Enter the difference on this line and carry forward to form FAM-43, line (09), (10), or (11) as appropriate.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
ABSENTEE BALLOTS

For State Controller Use Only

(19) Program Number 00002
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	AB-1.1, (03)		
(23)	AB-1.1, (06)		
(24)	AB-1.2, (03)(a)		
(25)	AB-1.2, (03)(b)		
(26)	AB-1.2, (03)(c)		
(27)	AB-1.2, (03)(d)		
(28)	AB-1.2, (05)		
(29)	AB-1.3, (03)(a)		
(30)	AB-1.3, (03)(b)		
(31)	AB-1.3, (03)(c)		
(32)	AB-1.3, (03)(d)		
(33)	AB-1.3, (04)(d)		
(34)	AB-1.3, (05)		
(35)			
(36)			
(37)			

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 77, Statutes of 1978 and Chapter 920, Statutes of 1994, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 77, Statutes of 1978 and Chapter 920, Statutes of 1994.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 77, Statutes of 1978 and Chapter 920, Statutes of 1994, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

ABSENTEE BALLOTS **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form AB-1.1, 1.2, or 1.3, as applicable, and enter the total claimed amount.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form AB-1.1, 1.2, or 1.3.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. AB-1.1, (03), means the information is located on form AB-1.1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
MENTALLY DISORDERED SEX OFFENDERS: EXTENDED COMMITMENTS

For State Controller Use Only

(19) Program Number 00039
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) MDSO-1, (03)			
(23) MDSO-1, (04)(d)			
(24) MDSO-1, (05)			
(25)			
(26)			
(27)			
(28)			
(29)			
(30)			
(31)			
(32)			
(33)			
(34)			
(35)			
(36)			
(37)			

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 991, Statutes of 1979, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 991, Statutes of 1979.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 991, Statutes of 1979, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

MENTALLY DISORDERED SEX OFFENDERS: EXTENDED COMMITMENTS **Certification Claim Form** **Instructions**	**FORM FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form MDSO-1 and enter the amount from line (10).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form MDSO-1, line (10).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. MDSO-1, (03), means the information is located on form MDSO-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
REGIONAL HOUSING NEED DETERMINATION

For State Controller Use Only

(19) Program Number 00055
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	RH-1, (04)(1)(f)	
(23)	RH-1, (04)(2)(f)	
(24)	RH-1, (04)(3)(f)	
(25)	RH-1, (04)(4)(f)	
(26)	RH-1, (04)(5)(f)	
(27)	RH-1, (04)(6)(f)	
(28)	RH-1, (04)(7)(f)	
(29)	RH-1, (04)(8)(f)	
(30)	RH-1, (06)	
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1143, Statutes of 1980, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1143, Statutes of 1980.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1143, Statutes of 1980, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

REGIONAL HOUSING NEED DETERMINATION Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form RH-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form RH-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. RH-1, (04)(1)(f), means the information is located on form RH-1, line (04)(1)(f). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
MENTALLY RETARDED DEFENDANTS: DIVERSION

For State Controller Use Only

(19) Program Number 00066
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	MRD-1, (03)(1)	
(23)	MRD-1, (03)(2)	
(24)	MRD-1, (04)(1)(d)	
(25)	MRD-1, (04)(2)(d)	
(26)	MRD-1, (06)	
(27)		
(28)		
(29)		
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1253, Statutes of 1980, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1253, Statutes of 1980.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1253, Statutes of 1980, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

MENTALLY RETARDED DEFENDANTS: DIVERSION **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form MRD-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form MRD-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. MRD-1, (03)(1), means the information is located on form MRD-1, line (03)(1). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
CONSERVATORSHIP: DEVELOPMENTALLY DISABLED ADULTS

For State Controller Use Only

(19) Program Number 00067
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	CDDA-1, (03)(1)	
(23)	CDDA-1, (03)(2)	
(24)	CDDA-1, (04)(1)(d)	
(25)	CDDA-1, (04)(2)(d)	
(26)	CDDA-1, (06)	
(27)		
(28)		
(29)		
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1304, Statutes of 1980, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1304, Statutes of 1980.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1304, Statutes of 1980, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

CONSERVATORSHIP: DEVELOPMENTALLY DISABLED ADULTS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form CDDA-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form CDDA-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. CDDA-1, (03)(1), means the information is located on form CDDA-1, line (03)(1). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
MEDI-CAL BENEFICIARY DEATH NOTICES

For State Controller Use Only

(19) Program Number 00043
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) MBD-1, (03)			
(23) MBD-1, (05)(e)			
(24)			
(25)			
(26)			
(27)			
(28)			
(29)			
(30)			
(31)			
(32)			
(33)			
(34)			
(35)			
(36)			
(37)			

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 102, Statutes of 1981 and Chapter 1163, Statutes of 1981; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 102, Statutes of 1981 and Chapter 1163, Statutes of 1981.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 102, Statutes of 1981 and Chapter 1163, Statutes of 1981, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

MEDI-CAL BENEFICIARY DEATH NOTICES Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form MBD-1 and enter the amount from line (08).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form MBD-1, line (08).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. MBD-1, (03), means the information is located on form MBD-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
PERMANENT ABSENT VOTERS

For State Controller Use Only

(19) Program Number 00083
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) PAV-1, (03)	
(23) PAV-1, (04)(1)(d)	
(24) PAV-1, (04)(2)(d)	
(25) PAV-1, (06)	
(26) PAV-1, (08)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1422, Statutes of 1982, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1422, Statutes of 1982.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1422, Statutes of 1982, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

PERMANENT ABSENT VOTERS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form PAV-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form PAV-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. PAV-1, (03), means the information is located on form PAV-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
FIREFIGHTERS CANCER PRESUMPTION

For State Controller Use Only

(19) Program Number 00023
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) FCP-1.1, (05)(3)			
(23) FCP-1.1, (06)(3)			
(24) FCP-1.2, (04)(1)(d)			
(25) FCP-1.2, (04)(2)(d)			
(26) FCP-1.2, (05)			
(27)			
(28)			
(29)			
(30)			
(31)			
(32)			
(33)			
(34)			
(35)			
(36)			
(37)			

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1568, Statutes of 1982, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1568, Statutes of 1982.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1568, Statutes of 1982, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

FIREFIGHTERS CANCER PRESUMPTION **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form FCP-1.1 or FCP-1.2, as applicable, and enter the total claimed amount.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form FCP-1.1, line (10) or FCP-1.2., line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. FCP-1.1, (05)(3), means the information is located on form FCP-1, line (05)(3). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SERVICES TO HANDICAPPED STUDENTS

For State Controller Use Only

(19) Program Number 00111
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data	
(22) HDS-1, (03)(a)	
(23) HDS-1, (03)(b)	
(24) HDS-1, (03)(c)	
(25) HDS-1, (04)(1)(d)	
(26) HDS-1, (04)(2)(d)	
(27) HDS-1, (04)(3)(d)	
(28) HDS-1, (04)(4)(d)	
(29) HDS-1, (04)(5)(d)	
(30) HDS-1, (06)	
(31) HDS-3, (05)	
(32) HDS-3, (06)	
(33) HDS-3, (07)	
(34)	
(35)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

SERVICES TO HANDICAPPED STUDENTS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form HDS-1 and enter the amount from line (11) or complete form HDS-3 and enter the amount from line (15).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form HDS-1, line (11) or from form HDS-3, line (15), as appropriate..

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. HDS-1, (03)(a), means the information is located on form HDS-1, line (03)(a). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
OPEN MEETINGS ACT

For State Controller Use Only

(19) Program Number 00049
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) OMA-1.1, (05)			
(23) OMA-1.1, (06)(d)			
(24) OMA-1.1, (07)			
(25)			
(26)			
(27)			
(28)			
(29)			
(30)			
(31)			
(32)			
(33)			
(34)			
(35)			
(36)			
(37)			

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 641, Statutes of 1986, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 641, Statutes of 1986.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 641, Statutes of 1986, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

OPEN MEETINGS ACT Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03), Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04), Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05), Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form OMA-1.1 and enter the amount from line (12). If more than one form OMA-1.1 is completed due to multiple department involvement in this mandate, add line (12) of each form OMA-1.1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09), Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10), Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11), Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form OMA-1, line (04).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17), Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18), Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. OMA-1.1, (05), means the information is located on form OMA-1, line (05). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
UNITARY COUNTYWIDE TAX RATE

For State Controller Use Only

(19) Program Number 00090
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	CTR-1, (03)(a)	
(23)	CTR-1, (03)(b)	
(24)	CTR-1, (04)(1)(e)	
(25)	CTR-1, (04)(2)(e)	
(26)	CTR-1, (04)(3)(e)	
(27)	CTR-1, (04)(4)(e)	
(28)	CTR-1, (04)(5)(e)	
(29)	CTR-1, (04)(6)(e)	
(30)	CTR-1, (06)	
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 921, Statutes of 1987, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 921, Statutes of 1987.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 921, Statutes of 1987, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

UNITARY COUNTYWIDE TAX RATE Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form CTR-1 and enter the amount from line (15). If more than one form CTR-1 is completed due to multiple department involvement in this mandate, add line (15) of each form CTR-1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form CTR-1, line (15). If more than one form CTR-1 is completed due to multiple department involvement in this mandate, add line (15) of each form CTR-1.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. CTR-1, (03)(a), means the information is located on form CTR-1, line (03)(a). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

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OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

MANDATED COSTS UNITARY COUNTYWIDE TAX RATE CLAIM SUMMARY	**FORM CTR-1**

(01) Claimant	(02) Type of Claim	Fiscal Year
	Reimbursement ☐	
	Estimated ☐	19___/20___

Claim Statistics

(03) (a) Total cost of preparing and mailing tax bills to properties in the 1986-87 fiscal year which were subsequently identified for assessment utilizing a unitary tax rate.	
(b) Number of unitary tax bills mailed in the fiscal year of claim.	

Direct Costs	**Object Accounts**				
(04) Reimbursable Components	(a) Salaries	(b) Benefits	(c) Services and Supplies	(d) Fixed Assets	(e) Total
1. Tax Bill Issuance					
2. Annual Compilation of Tax Rates					
3. Tax Roll Processing					
4. Allocation Formulas and Revenue Distribution					
5. Error Corrections					
6. Research and Explanations					
(05) Total Direct Costs					

Indirect Costs

(06) Indirect Cost Rate	[From ICRP]	%
(07) Total Indirect Costs	[Line (06) x line (05)(a)] or [line (06) x {line (05)(a) + line (05)(b)}]	
(08) Total Direct and Indirect Costs	[Line (05)(e) + line (07)]	

Cost Reduction

(09) 1986-87 Base Year Cost	[From line (03)(a)]	
(10) Change in the Implicit Price Deflator	[Enter the factor shown on back of this page]	
(11) Subtotal	[Multiply line (09) by line (10)]	
(12) Increased Costs	[Subtract line (11) from line (08)]	
(13) Less: Offsetting Savings, if applicable		
(14) Less: Other Reimbursements, if applicable		
(15) Total Claimed Amount	[Line (12) – {line (13) + line (14)}]	

UNITARY COUNTYWIDE TAX RATE CLAIM SUMMARY Instructions	FORM CTR-1

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

From CTR-1 must be filed for a reimbursement claim. Do not complete form CTR-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form CTR-1 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) (a) Enter the total cost of preparing and mailing tax bills to properties in the 1986-87 fiscal year were subsequently identified for assessment utilizing a unitary tax rate.

(b) Enter the number of unitary tax bills mailed in the fiscal year of claim.

(04) Reimbursable Components. For each reimbursable component, enter the totals from form CTR-2, line (05), columns (d), (e), (f), and (g) to form CTR-1, block (04), columns (a), (b), (c), (d), and (e) in the appropriate row. Total each row.

(05) Total Direct Costs. Total columns (a) through (e).

(06) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is reporting costs, each must have its own ICRP for the program.

(07) Total Indirect Costs. Multiply Total Salaries, line (05)(a), by the Indirect Cost Rate, line (06). If both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply total Salaries and Benefits, line (05)(a) and line (05)(b), by the Indirect Cost Rate, line (06).

(08) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (05)(e), and Total Indirect Costs, line (07).

(09) Enter the amount from line (03)(a), the 1986-87 Base Year Cost.

(10) Change in the Implicit Price Deflator. Enter the adjustment factor of 1.392 for the 1999-00 fiscal year.

(11) Subtotal. Multiply line (09) by line (10).

(12) Increased Costs. Subtract line (11) from line (08).

(13) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(14) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source, (i.e., service fees collected, federal funds, other state funds, etc.,) which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(15) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (13), and Other Reimbursements, line (14), from Increased Costs, line (12). Enter the remainder on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
BRENDON MAGUIRE ACT

For State Controller Use Only

(19) Program Number 00006
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) BMA-1, (03)	
(23) BMA-1, (04)(1)(d)	
(24) BMA-1, (04)(2)(d)	
(25) BMA-1, (04)(3)(d)	
(26) BMA-1, (06)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 391, Statutes of 1988, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 391, Statutes of 1988.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 391, Statutes of 1988, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

BRENDON MAGUIRE ACT **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form BMA-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form BMA-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. BMA-1, (03), means the information is located on form BMA-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SEARCH WARRANT: AIDS

For State Controller Use Only

(19) Program Number 00073
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	SWA-1, (03)(1)	
(23)	SWA-1, (03)(2)	
(24)	SWA-1, (04)(1)(d)	
(25)	SWA-1, (04)(2)(d)	
(26)	SWA-1, (04)(3)(d)	
(27)	SWA-1, (04)(4)(d)	
(28)	SWA-1, (06)	
(29)	SWA-1, (08)	
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1088, Statutes of 1988, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1088, Statutes of 1988.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1088, Statutes of 1988, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

SEARCH WARRANT: AIDS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form SWA-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form SWA-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. SWA-1, (03)(1), means the information is located on form SWA-1, line (03)(1). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
AIDS TESTING

For State Controller Use Only

(19) Program Number 00001
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	AT-1, (03)(1)	
(23)	AT-1, (03)(2)	
(24)	AT-1, (03)(3)	
(25)	AT-1, (03)(4)	
(26)	AT-1, (03)(5)	
(27)	AT-1, (04)(1)(d)	
(28)	AT-1, (04)(2)(d)	
(29)	AT-1, (04)(3)(d)	
(30)	AT-1, (04)(4)(d)	
(31)	AT-1, (04)(5)(d)	
(32)	AT-1, (06)	
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1597, Statutes of 1988, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1597, Statutes of 1988.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1597, Statutes of 1988, set forth on the attached statements.

Signature of Authorized Representative Date

_____ _____

_____ _____

Type or Print Name Title

(39) Name of Contact Person for Claim

Telephone Number (_____) _____ _____ Ext. _____

_____ E-mail Address _____

AIDS TESTING Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form AT-1 and enter the amount from line (11). If more than one form AT-1 are completed due to multiple department involvement in this mandate, add line (11) of each form AT-1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form AT-1, line (11). If more than one form AT-1 are completed due to multiple department involvement in this mandate, add line (11) of each form AT-1.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. AT-1, (03)(1), means the information is located on form AT-1, line (03)(1). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SUDDEN INFANT DEATH SYNDROME: AUTOPSY PROTOCOLS

For State Controller Use Only

(19) Program Number 00110
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) AP-1, (03)			
(23) AP-1, (04)(1)(d)			
(24) AP-1, (04)(2)(d)			
(25) AP-1, (04)(3)(d)			
(26) AP-1, (04)(4)(d)			
(27) AP-1, (04)(5)(d)			
(28)			
(29)			
(30)			
(31)			
(32)			
(33)			
(34)			
(35)			
(36)			
(37)			

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 955, Statutes of 1989, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 955, Statutes of 1989.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 955, Statutes of 1989, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

SUDDEN INFANT DEATH SYNDROME: AUTOPSY PROTOCOLS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form AP-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form AP-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. AP-1, (03), means the information is located on form AP-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SUDDEN INFANT DEATH SYNDROME TRAINING FOR FIREFIGHTERS

For State Controller Use Only

(19) Program Number 00180
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) STF-1, (03)(a)	
(23) STF-1, (03)(b)	
(24) STF-1, (04)(1)(e)	
(25) STF-1, (04)(2)(e)	
(26) STF-1, (06)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1111, Statutes of 1989, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1111, Statutes of 1989.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1111, Statutes of 1989, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

SUDDEN INFANT DEATH SYNDROME TRAINING FOR FIREFIGHTERS **Certification Claim Form** **Instructions**	**FORM FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form STF-1 and enter the amount from line (11). If more than one form STF-1 is completed due to multiple department involvement in this mandate, add line (11) of each form STF-1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form STF-1, line (11).

(14) Filing Deadline. Initial Claims of Ch. 1111/99. If the reimbursement claim for the fiscal years 1990/91, 1991/92, 1992/93, 1993/94, 1994/95, 1995/96, 1996/97, or 1997/98 fiscal year is filed after November 1, 1999, the claim must be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less. In subsequent years, reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. STF-1, (03)(a), means the information is located on form STF-1, line (03)(a). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
CANCER PRESUMPTION-PEACE OFFICERS

For State Controller Use Only

(19) Program Number 00118
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) CPO-1.1, (05)(3)			
(23) CPO-1.1, (06)(3)			
(24) CPO-1.2, (04)(1)(d)			
(25) CPO-1.2, (04)(2)(d)			
(26) CPO-1.2, (06)			
(27)			
(28)			
(29)			
(30)			
(31)			
(32)			
(33)			
(34)			
(35)			
(36)			
(37)			

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1171, Statutes of 1989, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1171, Statutes of 1989.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1171, Statutes of 1989, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

CANCER PRESUMPTION-PEACE OFFICERS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form CPO-1.1 or CPO-1.2, as applicable, and enter the total claimed amount.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form CPO-1 line (10) or CPO-1.2 line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. CPO-1.1, (05)(3), means the information is located on form CPO-1.1, line (05)(3). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
PESTICIDE USE REPORTS

For State Controller Use Only

(19) Program Number 00121
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) PUR-1, (03)	
(23) PUR-1, (04)(1)(d)	
(24) PUR-1, (04)(2)(d)	
(25) PUR-1, (04)(3)(d)	
(26) PUR-1, (06)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1200, Statutes of 1989, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1200, Statutes of 1989.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1200, Statutes of 1989, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

PESTICIDE USE REPORTS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form PUR-1 and enter the amount from line (11). If more than one form PUR-1 is completed due to multiple department involvement in this mandate, add line (11) of each form PUR-1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form PUR-1, line (11). If more than one form PUR-1 is completed due to multiple department involvement in this mandate, add line (11) of each form PUR-1.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. PUR-1, (03), means the information is located on form PUR-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
STOLEN VEHICLE NOTIFICATION

For State Controller Use Only

(19) Program Number 00120
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) SVN-1, (03)	
(23) SVN-1, (04)(1)(d)	
(24) SVN-1, (05)	
(25)	
(26)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 337, Statutes of 1990, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 337, Statutes of 1990.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 337, Statutes of 1990, set forth on the attached statements.

Signature of Authorized Representative Date

_____ _____

_____ _____

Type or Print Name Title

(39) Name of Contact Person for Claim

Telephone Number (_____) _____ _____ Ext. _____

_____ E-mail Address _____

STOLEN VEHICLE NOTIFICATION Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form SVN-1 and enter the amount from line (10).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form SVN-1, line (10).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. SVN-1, (03), means the information is located on form SVN-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

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ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
PERINATAL SERVICES

For State Controller Use Only

(19) Program Number 00124
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	PS-1, (03)	
(23)	PS-1, (04)(1)(d)	
(24)	PS-1, (04)(2)(d)	
(25)	PS-1, (04)(3)(d)	
(26)	PS-1, (04)(4)(d)	
(27)	PS-1, (06)	
(28)		
(29)		
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1603, Statutes of 1990, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1603, Statutes of 1990.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1603, Statutes of 1990, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

PERINATAL SERVICES Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form PS-1 and enter the amount from line (11). If more than one form PS-1 is completed due to multiple department involvement in this mandate, add line (11) of each form PS-1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form PS-1, line (11). If more than one form PS-1 is completed due to multiple department involvement in this mandate, add line (11) of each form PS-1.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. PS-1, (03), means the information is located on form PS-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SIDS: CONTACT BY LOCAL HEALTH OFFICER

For State Controller Use Only

(19) Program Number 00125
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) SIDS-1, (03)	
(23) SIDS-1, (04)(1)(d)	
(24) SIDS-1, (04)(2)(d)	
(25) SIDS-1, (06)	
(26)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 268, Statutes of 1991, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 268, Statutes of 1991.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 268, Statutes of 1991, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

SIDS: CONTACT BY LOCAL HEALTH OFFICER Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form SIDS-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form SIDS-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. SIDS-1, (03), means the information is located on form SIDS-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
PRISONER PARENTAL RIGHTS

For State Controller Use Only

(19) Program Number 00128
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) PPR-1, (03)	
(23) PPR-1, (04)(1)(d)	
(24) PPR-1, (04)(2)(d)	
(25) PPR-1, (06)	
(26)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 820, Statutes of 1991, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 820, Statutes of 1991.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 820, Statutes of 1991, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

PRISONER PARENTAL RIGHTS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form PPR-1 and enter the amount from line (11). If more than one for PPR-1 is completed due to multiple department involvement in this mandate, add line (11) of each form PPR-1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form PPR-1, line (11).). If more than one for PPR-1 is completed due to multiple department involvement in this mandate, add line (11) of each form PPR-1.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. PPR-1, (03), means the information is located on form PPR-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
RAPE VICTIM COUNSELING CENTER NOTICES

For State Controller Use Only

(19) Program Number 00127
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22) RVC-1, (03)	
(23) RVC-1, (04)(1)(d)	
(24) RVC-1, (04)(2)(d)	
(25) RVC-1, (06)	
(26) RVC-1, (08)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 999, Statutes of 1991 and Chapter 224, Statutes of 1992; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 999, Statutes of 1991 and Chapter 224, Statutes of 1992.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 999, Statutes of 1991 and Chapter 224, Statutes of 1992, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

RAPE VICTIM COUNSELING CENTER NOTICES **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form RVC-1 and enter the amount from line (11). If more than one form is completed due to multiple department involvement in this mandate, add line (11) of each form.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form RVC-1, line (11). If more than one form is completed due to multiple department involvement in this mandate, add line (11) of each form.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. RVC-1, (03), means the information is located on form RVC-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
DOMESTIC VIOLENCE TREATMENT SERVICES AUTHORIZATION AND CASE MANAGEMENT

For State Controller Use Only

(19) Program Number 00177
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

Type of Claim	**Estimated Claim**	**Reimbursement Claim**	(22) DVTS-1, (03)(a)
	(03) Estimated ☐	(09) Reimbursement ☐	(23) DVTS-1, (03)(b)
	(04) Combined ☐	(10) Combined ☐	(24) DVTS-1, (04)(1)(f)
	(05) Amended ☐	(11) Amended ☐	(25) DVTS-1, (04)(2)(f)
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___	(26) DVTS-1, (04)(3)(f)
Total Claimed Amount	(07)	(13)	(27) DVTS-1, (06)
Less: **10% Late Penalty, not to exceed $1,000**		(14)	(28)
Less: **Estimated Claim Payment Received**		(15)	(29)
Net Claimed Amount		(16)	(30)
Due from State	(08)	(17)	(31)
Due to State		(18)	(32)
			(33)
			(34)
			(35)
			(36)
			(37)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 183, Statutes of 1992, Chapter 184, Statutes of 1992, Chapter 28, Statutes of1994, and Chapter 641, Statutes of 1995; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 183, Statutes of 1992, Chapter 184, Statutes of 1992, Chapter 28, Statutes of1994, and Chapter 641, Statutes of 1995.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 183, Statutes of 1992, Chapter 184, Statutes of 1992, Chapter 28, Statutes of1994, and Chapter 641, Statutes of 1995, set forth on the attached statements.

Signature of Authorized Representative Date

_____ _____

_____ _____

Type or Print Name Title

(39) Name of Contact Person for Claim

Telephone Number (_____) _____ _____ Ext. _____

_____ E-mail Address _____

DOMESTIC VIOLENCE TREATMENT SERVICES AUTHORIZATION AND CASE MANAGEMENT **Certification Claim Form** **Instructions**	**FORM FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form DVTS-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form DVTS-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. DVTS-1, (03)(a), means the information is located on form DVTS-1, line (03)(a). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT

Pursuant to Government Code Section 17561

ALLOCATION OF PROPERTY TAX REVENUE: EDUCATIONAL REVENUE AUGMENTATION FUNDS

For State Controller Use Only

(19) Program Number 00152
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	ERAF-1, (03)	
(23)	ERAF-1, (04)(1)(e)	
(24)	ERAF-1, (04)(2)(e)	
(25)	ERAF-1, (04)(3)(e)	
(26)	ERAF-1, (06)	
(27)		
(28)		
(29)		
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 697, Statutes of 1992, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 697, Statutes of 1992.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 697, Statutes of 1992, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

ALLOCATION OF PROPERTY TAX REVENUE: EDUCATIONAL REVENUE AUGMENTATION FUNDS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form ERAF-1 and enter the amount from line (11). If more than one form ERAF-1 is completed due to multiple department involvement in this mandate, add line (11) of each form ERAF-1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form ERAF-1, line (11). If more than one form ERAF-1 is completed due to multiple department involvement in this mandate, add line (11) of each form ERAF-1.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. ERAF-1, (03), means the information is located on form ERAF-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
PACIFIC BEACH SAFETY

For State Controller Use Only

(19) Program Number 00122
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	PBS-1, (03)	
(23)	PBS-1, (04)(1)(d)	
(24)	PBS-1, (04)(2)(d)	
(25)	PBS-1, (06)	
(26)		
(27)		
(28)		
(29)		
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 961, Statutes of 1992, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 961, Statutes of 1992.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 961, Statutes of 1992, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

PACIFIC BEACH SAFETY Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form PBS-1 and enter the amount from line (11). If more than one form PBS-1 is completed due to multiple department involvement in this mandate, add line (11) of each form PBS-1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form PBS-1, line (11). If more than one form PBS-1 is completed due to multiple department involvement in this mandate, add line (11) of each form PBS-1.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. PBS-1, (03), means the information is located on form PBS-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
MISDEMEANORS: BOOKING AND FINGERPRINTING

For State Controller Use Only

(19) Program Number 00138
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) MBF-1, (03)	
(23) MBF-1, (04)(1)(d)	
(24) MBF-1, (04)(2)(d)	
(25) MBF-1, (06)	
(26)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1105, Statutes of 1992, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1105, Statutes of 1992.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1105, Statutes of 1992, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

MISDEMEANORS: BOOKING AND FINGERPRINTING **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form MBF-1 and enter the amount from line (11). If more than one form MBF-1 is completed due to multiple involvement in this mandate, add line (11) of each form.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form MBF-1, line (11). If more than one form MBF-1 is completed due to multiple involvement in this mandate, add line (11) of each form.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. MBF-1, (03), means the information is located on form MBF-1, line (03)(a). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
VERY HIGH FIRE HAZARD SEVERITY ZONES

For State Controller Use Only

(19) Program Number 00181
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) VHFH-1, (03)	
(23) VHFH-1, (04)(1)(f)	
(24) VHFH-1, (04)(2)(f)	
(25) VHFH-1, (04)(3)(f)	
(26)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	(27) VHFH-1, (06)
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1188, Statutes of 1992, Chapter 843 Statutes of 1994, and Chapter 333, Statutes of 1995 and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1188, Statutes of 1992, Chapter 843, Statutes of 1994, and Chapter 333, Statutes of 1995.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1188, Statutes of 1992, Chapter 843, Statutes of 1994, and Chapter 333, Statutes of 1995, set forth on the attached statements.

Signature of Authorized Representative Date

_____ _____

_____ _____

Type or Print Name Title

(39) Name of Contact Person for Claim

Telephone Number (_____) _____ _____ Ext. _____

_____ E-mail Address _____

VERY HIGH FIRE HAZARD SEVERITY ZONES **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form VHFH-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form VHFH-1, line (11).

(14) Filing Deadline. Initial Claims of Ch. 1188/92, 843/94, and 333/95. If the reimbursement claim for the fiscal year 1996-97, 1997-98, or 1998-99, is filed after February 28, 2000, the claim must be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

In subsequent years, reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (25) for the reimbursement claim e.g. VHFH-1, (03), means the information is located on form VHFH-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35.32% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
THREATS AGAINST PEACE OFFICERS

For State Controller Use Only

(19) Program Number 00163
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) TAP-1, (03)	
(23) TAP-1, (04)(1)(e)	
(24) TAP-1, (04)(2)(e)	
(25) TAP-1, (06)	
(26)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1249, Statutes of 1992 and Chapter 666, Statutes of 1995 and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1249, Statutes of 1992 and Chapter 666, Statutes of 1995.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1249, Statutes of 1992 and Chapter 666, Statutes of 1995, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

THREATS AGAINST PEACE OFFICERS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form TAP-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form TAP-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. TAP-1, (03), means the information is located on form TAP-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

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ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
AIRPORT LAND USE PLANS/COMMISSIONS

For State Controller Use Only

(19) Program Number 00178
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	ALUC-1, (04)(1)(f)	
(23)	ALUC-1, (04)(2)(f)	
(24)	ALUC-1, (06)	
(25)		
(26)		
(27)		
(28)		
(29)		
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 644, Statutes of 1994, Chapter 66, Statutes of 1995, and Chapter 91, Statutes of 1995; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by by Chapter 644, Statutes of 1994, Chapter 66, Statutes of 1995, and Chapter 91, Statutes of 1995.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of by Chapter 644, Statutes of 1994, Chapter 66, Statutes of 1995, and Chapter 91, Statutes of 1995, set forth on the attached statements.

Signature of Authorized Representative Date

_____ _____

_____ _____

Type or Print Name Title

(39) Name of Contact Person for Claim

Telephone Number (_____) _____ _____ Ext. _____

_____ E-mail Address _____

AIRPORT LAND USE PLANS/COMMISSIONS **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form ALUC-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form ALUC-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. ALUC-1, (04)(1)(f), means the information is located on form ALUC-1, line (04)(1)(f). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
TWO-WAY TRAFFIC SIGNAL COMMUNICATION

For State Controller Use Only

(19) Program Number 00174
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) TTSC-1, (03)	
(23) TTSC-1, (04)(1)(f)	
(24) TTSC-1, (04)(2)(f)	
(25) TTSC-1, (04)(3)(f)	
(26) TTSC-1, (06)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1297, Statutes of 1994, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1297, Statutes of 1994.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1297, Statutes of 1994, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

TWO-WAY TRAFFIC SIGNAL COMMUNICATION **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form TTSC-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form TTSC-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. TTSC-1, (03), means the information is located on form TTSC-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
DOMESTIC VIOLENCE ARREST POLICIES AND STANDARDS

For State Controller Use Only

(19) Program Number 00167
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) DAPS-1, (04)(1)(f)	
(23) DAPS-1, (04)(2)(f)	
(24) DAPS-1, (04)(3)(f)	
(25) DAPS-1, (06)	
(26)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 246, Statutes of 1995, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 246, Statutes of 1995.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 246, Statutes of 1995, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

DOMESTIC VIOLENCE ARREST POLICIES AND STANDARDS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form DAPS-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form DAPS-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. DAPS-1, (04)(1)(f), means the information is located on form DAPS-1, line (04)(1)(f). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

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Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
CRIME VICTIMS' RIGHTS

For State Controller Use Only

(19) Program Number 00158
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) CVR-1, (03)	
(23) CVR-1, (04)(1)(e)	
(24) CVR-1, (04)(2)(e)	
(25) CVR-1, (06)	
(26)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 411, Statutes of 1995, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 411, Statutes of 1995.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 411, Statutes of 1995, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

CRIME VICTIMS' RIGHTS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form CVR-1 and enter the amount from line (11). If more than one form CVR-1 is completed due to multiple department involvement in this mandate, add line (11) of each form CVR-1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form CVR-1, line (11). If more than one form CVR-1 is completed due to multiple department involvement in this mandate, add line (11) of each form CVR-1.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. CVR-1, (03), means the information is located on form CVR-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SEXUALLY VIOLENT PREDATORS

For State Controller Use Only

(19) Program Number 00175
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data		
(22)		
(23)		
(24)		
(25)		
(26)		
(27)		
(28)		
(29)		
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 762, Statutes of 1995, Chapter 763, Statutes of 1995, and Chapter 4, Statutes of 1996; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 762, Statutes of 1995, Chapter 763, Statutes of 1995, and Chapter 4, Statutes of 1996.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 762, Statutes of 1995, Chapter 763, Statutes of 1995, and Chapter 4, Statutes of 1996, set forth on the attached statements.

Signature of Authorized Representative Date

_____ _____

_____ _____

Type or Print Name Title

(39) Name of Contact Person for Claim Telephone Number (_____) _____ _____ Ext. _____

_____ E-mail Address _____

SEXUALLY VIOLENT PREDATORS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form SVP-1 and enter the amount from line (05).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form SVP-1, line (05).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (37) Leave blank.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
INVESTMENT REPORTS

For State Controller Use Only

(19) Program Number 00161
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) INR-1, (03)			
(23) INR-1, (04)(1)(f)			
(24) INR-1, (04)(2)(f)			
(25) INR-1, (06)			
(26)			
(27)			
(28)			
(29)			
(30)			
(31)			
(32)			
(33)			
(34)			
(35)			
(36)			
(37)			

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 783, Statutes of 1995 Chapter 156, Statutes of 1996, and Chapter 749, Statutes of 1996; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 783, Statutes of 1995 Chapter 156, Statutes of 1996, and Chapter 749, Statutes of 1996.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 783, Statutes of 1995 Chapter 156, Statutes of 1996, and Chapter 749, Statutes of 1996, set forth on the attached statements.

Signature of Authorized Representative Date

_____ _____

_____ _____

Type or Print Name Title

(39) Name of Contact Person for Claim

Telephone Number (_____) _____ _____ Ext. _____

_____ E-mail Address _____

INVESTMENT REPORTS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

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(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form INR-1 and enter the amount from line (11). If more than one form INR-1 is completed due to multiple department involvement in this mandate, add line (11) of each form INR-1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

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(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form INR-1, line (11). If more than one form INR-1 is completed due to multiple department involvement in this mandate, add line (11) of each form INR-1.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

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(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. INR-1, (03), means the information is located on form INR-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

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Sacramento, CA 94250

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OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816